Commonwealth of Massachusetts
Department of Mental Health

APPLICATION FOR ADULT CONTINUING CARE SERVICES (June 20, 2003)

INSTRUCTIONS:
This form is for applicants **19 years of age or older**.

The applicant, his or her legal guardian, or someone assisting the applicant, should complete
® **SECTION 1**.

A treating clinician or other person with knowledge of the applicant's history should complete
® **SECTION 2** of the application and the
® **CLINICAL ASSESSMENT OF RISK, BEHAVIOR AND REHABILITATION NEEDS OF ADULTS**.

These sections and the signed
® **AUTHORIZATION FOR DMH ELIGIBILITY DETERMINATION** must be returned to the Department of Mental Health Eligibility Unit serving the applicant's area of the state.

DMH Eligibility Units:

Western Massachusetts Area Eligibility Determination Unit
P.O. Box 389, Northampton, MA 01061-0389
Phone: (413) 587-6200 Fax: (413) 587-6205

Central Massachusetts Area Eligibility Determination Unit
305 Belmont Street, Worcester, MA 01604
Phone: (508) 368-3838 Fax: (508) 363-1500

Metro Suburban Area Eligibility Determination Unit
P.O. Box 288 – Lyman Street, Westboro, MA 01581
Phone: (508) 616-2186 Fax (508) 616-3599

North East Area Eligibility Determination Unit
P.O. Box 387, Tewksbury, MA 01876-0387
Phone: (978) 863-5000 Fax (978) 863-5091

Metro Boston Area Eligibility Determination Unit
85 East Newton Street, Boston, MA 02118
Phone: (617) 626-9217 Fax: (617) 626-9216

Southeastern Area Eligibility Determination Unit
165 Quincy Street, Brockton, MA 02302
Phone: (508) 897-2000 Fax (508) 897-2024

DMH Information and Referral service: 1-800-221-0053 (regular business hours only)

DMH web site: www.state.ma.us/dmh

Commonwealth of Massachusetts
Department of Mental Health

APPLICATION FOR ADULT CONTINUING CARE SERVICES (June 20, 2003)

SECTION 1: PERSONAL INFORMATION – completed by the applicant, his or her legal guardian, or someone assisting the applicant

1. Name _____ 2. SSN _____
(Last) (First) (Mi) (Social Security Number)

3. Address _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

4. Telephone ( )_____ ( )_____
day evening

5. Birth Date _____ 6. Age _____ 7. Gender _____ 8. Race/Ethnicity_____
(MM / DD / YY) (In Years) M / F

9. Does applicant speak English? ☐ Yes ☐ No ☐ Limited 10. Preferred Language/Dialect_____

11. Literate in English? ☐ Yes ☐ No ☐ Limited
11a. Literacy in the applicant's native language? ☐ Yes ☐ No ☐ Limited

12. Citizenship _____ 13. Country of origin _____ 14. Length of stay in U.S. _____

15. Religion _____

16. Does applicant have a court appointed legal guardian? ☐ Yes ☐ No

17. Name of legal guardian _____Relationship _____
(Last) (First) (to Applicant)

18. Telephone ( ) _____ ( ) _____
day evening

19. Emergency contact person_____ 20.Telephone ( ) _____
(Last) (First)

21. **HEALTH INSURANCE** a) ☐ No health insurance b) ☐ No mental health benefit

c) ☐ Application for Health Insurance Pending

d) ☐ Medicare e) ☐ Medicare/Medicaid

f) ☐ Medicaid/MassHealth Card #: _____ g) RID #:_____

MassHealth Provider
h) ☐ HMO _____ i) ☐ Primary Care Clinician Program (PCC) j) ☐ Other_____
(Name of HMO)

k) ☐ Private insurance l) Name of Insurance: _____ m) Policy #:_____

n) Name of Policy Holder: _____

22. **SOURCE OF INCOME**

a) ☐ Employment b) ☐ SSDI c) ☐ SSI d) ☐ EAEDC e) ☐ Social Security f) ☐ Family

g) ☐ Other sources If other, explain:_____ h) Estimated Personal Monthly Income:_____

Applicant Name:

SECTION 1, continued:

23. **MENTAL HEALTH CARE PROVIDER (to be filled out by applicant)**
Who provides regular mental health care? If there is no regular provider of mental health care, please use this section to indicate the most recent source of mental health care.

a) Primary Mental Health Provider _____, _____ b) Check if current provider ☐
(Last) (First) (Degree)

c) HMO, Clinic or Hospital name, if applicable _____

d) Address _____
(Number and Street) (Office Number/Location) (City) (State) (Zip Code)

e) Telephone ( )_____ Extension _____

24. **OTHER RECENT MENTAL HEALTH PROVIDERS**
Please list all mental health services received ***during the past 24 months,*** **including hospitalizations.** In addition, list any other sources of medical information to be considered in the determination of eligibility. Attach additional pages if necessary.

Name of the mental health provider where services were received (e.g., MD, hospital, agency clinic)	Type of service (e.g., inpatient, outpatient, day, residential, substance abuse)	Current provider? Yes or No

APPLICATION FOR ADULT CONTINUING CARE SERVICES (June 20, 2003)

Applicant Name: _____

SECTION 2 begins here, to be completed by clinician or other person with knowledge of applicant's history. Individuals who are not clinicians but are completing this section should leave blank any questions when they are not sure about the answers. For assistance, call the Eligibility Unit for your area at the telephone number listed.

Name of person completing this section, credentials, describe how long you have known the applicant:

1. What is the applicant's presenting psychiatric problem(s)?

2. What are the applicant's functional impairments? How do the functional impairments relate to the presenting psychiatric problems and/or diagnosis?

2a. What are the applicant's strengths?

3. How many months during the past twelve months has the applicant been functioning at the current impairment level?

4. How many months do you anticipate that the applicant will continue to experience severe functional impairment?

Why?

Applicant Name:

5. Applicant's current medications, dosages and start dates:

6. How are the primary problems being addressed in treatment or during this hospitalization?

NOTE: the clinician must ask the applicant directly for responses to 7a-d

7. **During the past six months**:

a) Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants.) ☐ Yes ☐ No

b) Have you felt that you use too much alcohol or other drugs? ☐ Yes ☐ No

c) Have you tried to cut down or quit drinking or using drugs? ☐ Yes ☐ No

d) Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) ☐ Yes ☐ No

Comments:

8. **CULTURAL OR LINGUISTIC PREFERENCES AND CONCERNS**

Is there anything in the applicant's cultural experience or tradition that:
Has presented a barrier to the applicant receiving services?
Affects the way that services should be provided? If yes to either, please explain:

Applicant Name:

9. **FAMILY SUPPORTS AND OBLIGATIONS**

a. Is the applicant the parent of a minor child? ☐ Yes ☐ No

b. If yes, is the Department of Social Services (DSS) involved in the care of the child in any way? ☐ Yes ☐ No

Applicants who are parents of children with DSS involvement will be offered temporary support during the DMH application process. Continuation of the services will depend on final DMH eligibility status.

c. Please list each immediate family member and significant other living in the household, and all minor children, regardless of where they live:

Name, approximate age	Relationship	Living arrangement

d. How have family members been providing support to the applicant?

10. **ANY OTHER INFORMATION YOU THINK WOULD BE HELPFUL**

11. **To be filled out by clinician only (if no clinician is involved leave diagnoses blank):**

Please check one: ☐ **DSM IV DIAGNOSIS** ☐ **DIAGNOSTIC IMPRESSIONS**

PLEASE COMPLETE ALL AXES

Who is responsible for the above diagnosis or impressions?

Name:_____ **Credentials:**_____ **Date diagnosed:**_____

a) AXIS I _____ b) AXIS II _____

c) AXIS III _____ d) AXIS IV _____

e) AXIS V _____

Applicant Name:

AUTHORIZATION FOR DMH ELIGIBILITY DETERMINATION

- I request that the Department of Mental Health (DMH) conduct a determination of eligibility for continuing care services. I have attached signed release of information forms to this application if necessary. I understand that DMH will collect and review medical records as part of the determination of eligibility. I understand that my name and information about me will be included in a DMH record keeping system.
- DMH may, at its discretion, request a personal interview with me or a clinical evaluation in circumstances where the available clinical records are not sufficient to make a determination of eligibility.
- In addition, I will be required to disclose information about my income and insurance and may be charged for services according to my ability to pay.
- I also understand that I may appeal the decision of DMH in determining whether or not I am eligible for DMH continuing care services.
- I received a copy of the DMH Notice of Privacy Practices (appended to this application).

Signature of applicant or legal guardian of the person _____ Applicant Name (Print) _____ Date signed _____

PERSON ASSISTING APPLICANT

This section to be completed by provider or other person assisting applicant with the application.

Name _____ Relationship _____
(last) (first) (relationship to applicant)

Address _____
(number and street) (apt no) (city) (state) (zip code)

Telephone ( ) _____ ( ) _____
(day time) (evening)

PROGRAM OR FACILITY SUBMITTING APPLICATION ON BEHALF OF APPLICANT

This section to be completed by program or facility submitting application on behalf of applicant

Name of Program or Facility _____ Name of Applicant _____

☐ The applicant was informed on _____that an application was being filed on his/her behalf and he/she did not object
☐ The applicant is incapable and a petition for guardianship was filed in the appropriate court (copy of petition is attached)

Your Name (please print) _____ Your Signature and Title _____

TO SUBMIT RELEASE OF MEDICAL INFORMATION FORMS

As part of the determination of eligibility, the Department of Mental Health will review records of all mental health care provided to the applicant during the past 24 months.

1. Please submit one signed *Authorization for Release of Information* form for each provider of mental health care during the past 24 months. If mental health care was provided through a clinic, please identify a primary provider of care at that clinic.
2. In addition, please submit an *Authorization for Release of Information* form for any other clinical information the applicant would like to have considered as part of the determination of eligibility.
3. Please double check the accuracy of the provider's name, address, and phone number on each release form. Please make a phone call if necessary to verify information on the *Authorization for Release of Information* form. Correct names and addresses expedite the eligibility review process.
4. Please submit signed *Authorization for Release of Information* forms along with the application, if possible.

How many *Authorization for Release of Information* forms are being submitted with this application? ☐

The Department will also review any medical records that the applicant or those assisting the applicant may have in their possession and wish to submit for consideration.

1. Please complete and sign an *Authorization for Release of Information* form for each medical record that is attached to this application in case DMH staff need to clarify information contained in the report.
2. Copies of medical reports cannot be returned so please do not send original copies.

How many copies of medical reports are attached to this application? ☐

Commonwealth of Massachusetts
Department of Mental Health
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

*Protected Health Information (PHI)

PLEASE REVIEW IT CAREFULLY

Notice Effective Date: June 20, 2003
Version 3

Privacy

The Department of Mental Health (DMH) is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

DMH is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. DMH must follow the privacy practices as set forth in its most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice

DMH may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that DMH already has as well as PHI that DMH receives in the future. The most current privacy notice will be posted in DMH facilities and programs, and on the DMH website (www.state.ma.us/dmh), and will be available on request. Every privacy notice will be dated.

How Does DMH Use and Disclose PHI?

DMH may use/disclose your PHI for treatment, payment and health care operations without your

authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations

The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment – Consistent with its regulations and policies, DMH may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to determine your eligibility for DMH services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. Your PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care.

To obtain payment -- Consistent with the restrictions set forth in its regulations and policies, DMH may use/disclose your PHI to bill and collect payment for your health care services. DMH may release portions of your PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations -- DMH may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., JCAHO).

Appointment Reminders

DMH may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization

DMH is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent DMH has already acted based upon your authorization.

Exceptions

- For guardianship or commitment proceedings when DMH is a party
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, DMH may disclose a limited amount of PHI for the following purposes:
- **Clergy** – Your religious affiliation may be shared with clergy
- **To Family and Friends** – DMH may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate
- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- For specialized government functions such as government benefit programs relating to eligibility and enrollment
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

Your Rights

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that DMH use a specific address or telephone number to contact you. DMH is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- *Request additions or corrections to your PHI. DMH is not required to comply with a request. If it does not comply with your request, you have certain rights.
- *Receive a list of individuals who received your PHI from DMH (excluding disclosure that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
- *Ask that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to a restriction.

*** These requests must be made in writing**

To Contact DMH or to File a Complaint

If you want to obtain further information about DMH's privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact:
DMH Privacy Officer, Department of Mental Health, 25 Staniford Street, Boston, MA 02114,
Phone: 617-626-8160, Fax: 617-626-8077.
PrivacyOfficer@dmh.state.ma.us
A complaint must be made in writing.

You also may contact a DMH facility's medical records office (for that facility's records), a DMH program director (for that program's records), your site office (for case management records), or the human rights officer at your facility or program, for more information or assistance.

No one may retaliate against you for filing a complaint or for exercising your rights as described in this notice.

You also may file a complaint with the **Secretary of Health and Human Services**, Office of Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA 02203.

Applicant Name:

CLINICAL ASSESSMENT OF RISK, BEHAVIOR AND REHABILITATION NEEDS OF ADULTS ©

To be completed by the applicant's primary mental health provider or evaluator.

The Department is implementing the use of clinical assessment summary scaling. The intent of this approach is to ask experienced clinicians to use behavioral descriptions to summarize their impression of their client's functional difficulties during the six months prior to application for DMH continuing care services. The content of the clinical assessment scales deals with difficulties common to persons experiencing severe and persistent mental illness. The ratings summarize assessments and clinical judgment and should be completed by the applicant's primary mental health provider or recent evaluator. For each question, select the description that most closely summarizes the **applicant's functioning during the past six months**. If functioning is variable, indicate the lowest level of functioning during the past six months. If you do not have sufficient information or experience with the applicant to answer a particular question, write "DNK" in the white box next to that item.

How well do you know the applicant? Please describe:

Ability to avoid common hazards.

1. **Fully** (consistently avoids common hazards independently)
2. **Mostly** (independently avoids common hazards; may seek occasional help as needed)
3. **Somewhat** (avoids common hazards for at least brief periods of time but also uses assistance from others)
4. **Marginally** (relies on close external supervision and (re)direction to avoid common hazards)
5. **Rarely** (likely to both discontinue needed treatment and become unable to avoid common hazards)
6. **Not Able** (unable to avoid common hazards independently and not reliably (re) directable)

Ability to maintain adequate hygiene and nutrition (ADLs)

1. **Fully** (consistently cares for self independently)
2. **Mostly** (generally self-sufficient; may seek occasional help as needed)
3. **Somewhat** (has many skills which are exercised with prompts provided by others)
4. **Marginally** (relies on close supervision and (re)direction to perform ADLs)
5. **Rarely** (despite some ADL skills, poor judgment necessitates careful control of ADL supplies)
6. **Not Able** (unable to care for personal needs leading to life (health) endangering self-neglect)

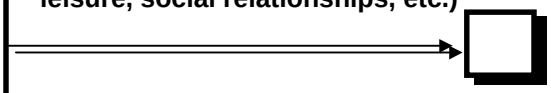
Ability to participate fully in individual recovery plan (treatment and rehabilitation such as symptom management, self-regulation, vocational training, substance abuse treatment, etc.).

1. **Fully** (takes full responsibility for his/her own recovery)
2. **Mostly** (generally self-sufficient in pursuing a recovery plan with only occasional prompts by others)
3. **Somewhat** (uses acquired skills together with assistance in order to pursue recovery plan)
4. **Marginally** (relies on close supervision and (re)direction to pursue recovery plan)
5. **Rarely** (minimally involved in or unable to use the treatment and rehabilitation provided)
6. **Not Able** (not engaged in treatment and rehabilitation)

Ability to self-medicate.

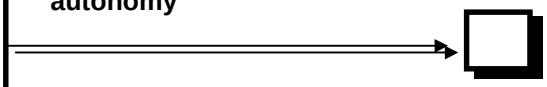
1. **Fully** (can and will medicate independently with outpatient office visits)
2. **Mostly** (generally able and willing to self-medicate with periodic monitoring)
3. **Somewhat** (can self-medicate provided he/she has prompts and observation)
4. **Marginally** (currently relies on prompts and licensed administration but may learn self-medication)
5. **Rarely** (non-compliant with medication plan despite ability to self-medicate)
6. **Not Able** (functionally unable to self-medicate, even with supervision)

Ability to carry out functional roles (e.g., work, leisure, social relationships, etc.)



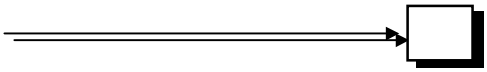
1. **Fully** (carries out roles needed for independent living)
2. **Mostly** (functional skills allow relative independence; may seek occasional help as needed)
3. **Somewhat** (uses acquired skills together with assistance from others to accomplish roles)
4. **Marginally** (relies on prompts and coaching from others but may develop functional role skills)
5. **Rarely** (frequently rejects attempts by others to meet social and occupational needs)
6. **Not Able** (dependent on others to meet social and occupational needs)

Ability to pursue greater personal autonomy



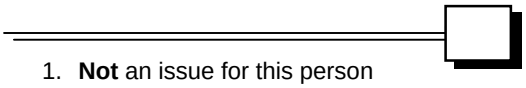
1. **Fully** (expresses preferences, takes responsibility for achieving greater autonomy)
2. **Mostly** (actively pursues assistance to formulate a recovery plan leading to greater autonomy)
3. **Somewha**t (despite difficulty with change, accepts responsibilities in a structured recovery plan)
4. **Marginally** (very anxious about change but accepts support for transitions)
5. **Rarely** (refuses less restrictive level of care or refuses services essential for safety at next level of care)
6. **Not Able** (pronounced regression and reemergence of dangerous behavior when environment changes)

Risk for physical violence towards others



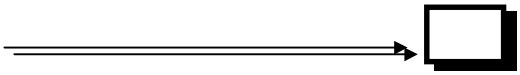
1. **Not** an issue for this person
2. **Minimal** (generally uses internal controls; may seek occasional help to control violent impulses)
3. **Low** (uses a combination of internal controls and assistance from others)
4. **Moderate** (relies on close supervision and (re)direction to control violent impulses)
5. **High** (occasional but not serious physical assaults in spite of external controls)
6. **Extreme** (serious or frequent physical assaults in spite of external controls)

Risk for sexual violence towards others



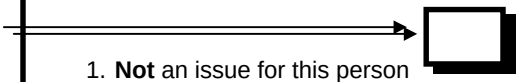
1. **Not** an issue for this person
2. **Minimal** (generally uses internal controls; may seek occasional help to control impulses to sexually assault)
3. **Low** (can use a combination of internal controls and assistance from others)
4. **Moderate** (relies on close supervision and (re)direction to control impulses to sexual violence)
5. **High** (exposure, fondling or occasional sexual assaults in spite of external controls)
6. **Extreme** (rape or other serious sexual assaults in spite of external controls)

Risk for suicidal or self-injurious behavior



1. **Not** an issue for this person
2. **Minimal** (generally uses internal controls; may seek occasional help to control impulses to self-harm)
3. **Low** (generally uses a combination of internal controls and assistance from others)
4. **Moderate** (relies on close supervision and (re)direction to prevent self-harm)
5. **High** (makes attempts at non-lethal forms of self harm in spite of external controls)
6. **Extreme** (makes attempts at potentially lethal self-harm in spite of external controls)

Risk of unacceptable behavior that has significant social consequences or is illegal (such as victimizing vulnerable individuals)



1. **Not** an issue for this person
2. **Minimal** (generally uses internal controls; may seek occasional help to control impulses)
3. **Low** (uses a combination of internal controls and assistance from others)
4. **Moderate** (relies on close supervision and (re)direction for social judgment)
5. **High** (violates social norms or victimizes others, possibly leading to forensic involvement)
6. **Extreme** (serious antisocial behavior results in victimization or forensic involvement)

Risk of significant health consequences from inability to comply with medical (non-psychiatric) treatment.

1. **Not** an issue for this person
2. **Minimal** (medical care is obtained independently through outpatient medical services)
3. **Low** (complies with regularly scheduled medical/nursing assessments or treatments with assistance)
4. **Moderate** (needs close monitoring of health status by a medical provider several times per week)
5. **High** (needs daily monitoring of health status and medications/treatments from a licensed nurse)
6. **Extreme** (needs 24 hour skilled nursing to prevent significant medical consequences)

Risk of problematic behaviors due to ORGANIC CONDITION(s), neurologic or neuropsychiatric

1. **Not** an issue for this person
2. **Minimal** (able to function independently with only occasional help in spite of organic condition)
3. **Low** (uses a combination of internal resources and assistance from others)
4. **Moderate** (relies on external controls and structures provided to maintain safety)
5. **High** (requires constant supervision to maintain safety)
6. **Extreme** (organic condition is irreversible and/or deteriorating; behavior is dangerous to self or others despite constant supervision)

Risk of Substance Abuse

1. **Not** an issue for this person
2. **Minimal** (able to maintain sobriety; seeks and uses supports according to need)
3. **Low** (utilizes regularly scheduled supports to maintain recovery)
4. **Moderate** (relies on close supervision and programming to maintain sobriety)
5. **High** (requires external controls to maintain the sobriety needed for safety)
6. **Extreme** (In the absence of secure care, substance-related behavior is dangerous to self or others)

Risk of separating self from psychiatrically necessary or court- ordered (forensic) care.

1. **Not** an issue for this person (independently secures psychiatric care)
2. **Minimal** (if separated from necessary care, the person is likely to return or seek appropriate help)
3. **Low** (unlikely to separate self from needed care, but benefits from some supervision)
4. **Moderate** (relies on close supervision and (re)direction to continue with care)
5. **High** (risk of leaving supervised care setting in spite of external controls)
6. **Extreme** (actively attempts to leave secure care setting)

CLINICAL SUMMARY 1

Dangerous Behaviors: Level of concern that there will be future dangerous behaviors

1. **Not** a concern (no or remote history of dangerous behavior
2. **Minimal** (despite history ,generally uses internal controls; may seek occasional help)
3. **Low** (despite history, uses a combination of internal controls and assistance from others)
4. **Moderate** (history of dangerous behavior, relies on external controls)
5. **High** (history of dangerous behavior, despite external controls may exhibit dangerous behavior)
6. **Extreme** (history of dangerous behavior, continues serious and/or frequent dangerous behavior)

CLINICAL SUMMARY 2

Behavioral Inconsistency: Level of concern about unpredictability of behavior

1. **Not** an issue for this person (behavior is stable)
2. **Minimal** (behavior is generally stable; weekly or less frequent monitoring sufficient)
3. **Low** (behavior is sufficiently stable to allow for observation not more than several times per day)
4. **Moderate** (somewhat inconsistent behavior, hourly observation and daily clinical assessment needed).
5. **High** (variable and inconsistent, more than hourly observation throughout the day and clinical assessment needed several times per day)
6. **Extreme** (unstable and unpredictable, requiring nearly continuous observation and clinical assessment at frequent intervals throughout the day)

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
One-Way To Department of Mental Health

Name: Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

I authorize the following person, facility or agency:

Name: Attention: Phone:

Street: City/Town: State: Zip:

to release information, either verbally or in writing to the Department of Mental Health (DMH).

DMH Contact Information:

Name: Phone:

Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g. Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & PSTP(s), Physical Exam & Lab Reports, Progress Note(s):

_____
_____
_____
_____
_____
_____
_____

Purpose for the authorization:

☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

or

☐ Coordinate care ☐ Facilitate billing
☐ Referral ☐ Obtain insurance, financial or other benefits
☐ Other purpose (please specify): _____

A copy of this authorization shall be considered as valid as the original.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information (continued)
One-Way To Department of Mental Health

Name of person/facility/agency to release information to DMH:_____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to the person, facility or agency authorized to release information to DMH. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. This authorization will expire in 12 months unless otherwise specified (specify a date, time period or an event):_____. I understand that once the above information is disclosed it may be redisclosed and no longer protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the person, facility or agency authorized to release information to DMH. However, lack of ability to share or obtain information may prevent DMH, and/or other person, facility or agency, from providing appropriate and necessary care.

_____ _____
Your signature or Personal Representative's signature Date

_____
Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) _____

Specially Authorized Releases of Information (please initial all that apply)

____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, or an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

_____ _____
Your signature or Personal Representative's signature Date

INSTRUCTIONS:
1. This form must be completed in full to be considered valid.
2. Distribution of copies: original to appropriate DMH record; copy to individual or Personal Representative.

DMH Form Authorization for Release of Information-One Way To DMH Page 2 of 2
HIPAA-F-7 (4/22/03)